MediCross Urgent Care & GP Clinic
8 Egmont Street | New Plymouth 4310

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I M P O R T A N T — It is preferable that your Travel Consultation appointment is made one month prior to your departure. Please return this record this form promptly to reception, or email to admin@medicross.co.nz at least four days before your appointment. All charges must be paid for at the time of the consultation.

P L E A S E N O T E – There will be a charge for each person for an extended consultation, even if your travel has been discussed previously with your own GP.

TRAVELLER'S MEDICAL RECORD

DATE _____

FIRST NAME _____ **SURNAME** _____

ADDRESS _____

_____ POST CODE _____

DATE OF BIRTH _____ ETHNICITY _____

TELEPHONE _____ MOBILE PHONE _____

I (FULL NAME)_____ hereby consent to the administration to myself of the vaccines as listed below.

YOUR HEALTH

1. **Have you travelled to less developed countries before?**
   ☐ **Yes** ☐ **No**

   Did you have any health problems while away? ☐ **Yes** ☐ **No**

   If yes, please specify.....

2. **Do you have or have you ever had any medical problems?** eg, asthma, chronic bronchitis, diabetes, stomach ulcer, splenectomy, epilepsy, heart disease, depression, schizophrenia, anxiety attacks, mental illness, weakness of immune system, HIV/AIDS, blood clots
   ☐ **Yes** ☐ **No**

   If yes, please specify.....

3. **Have you been in hospital in the last year?** ☐ **Yes** ☐ **No**
4. **Have you had a blood transfusion?** ☐ **Yes** ☐ **No**
5. **Have you ever had hepatitis?** ☐ **Yes** ☐ **No**
6. **Are you taking any medication now?** eg: contraceptive pill, antibiotics or do you occasionally take medication? eg: migraine tablets, ventolin, vitamins ☐ **Yes** ☐ **No**

   If yes, please specify.....

7. **Do you have any known allergies?** eg: sulphur drugs, eggs, nuts, penicillin, bee stings, iodine, neomycin, latex, band aids? ☐ **Yes** ☐ **No**

   If yes, please specify.....

8. **Women only: Are you pregnant or is it a possibility on your return?**

   ☐ **Yes** ☐ **No**

9. **Please list any past vaccinations and date/year of administration**:

BCG	Diphtheria/Tetanus	Typhoid
Hep A	Hep B	Meningitis
Influenza	MMR	Rabies
Polio	Yellow Fever	

   Other.....

10. **Do you have any particular health concerns regarding this trip?**

    ☐ **Yes** ☐ **No**

    Please outline .....

YOUR TRIP

11. **Please list in order the countries you intend visiting, and how long you plan to spend in each**:

    ....days

    ....days

    ....days

    ....days

    ....days

    ....days

    ....days

12. **What is the main purpose of your trip?** (Please circle)

    ☐ Holiday ☐ Visiting family/friends ☐ Business Trip

    ☐ Other _____

13. **Type of Accommodation?** (Please tick)

    ☐ Camping ☐ Budget ☐ Air Conditioned Hotel ☐ Private ☐ Home

    ☐ Other _____

14. **Planned activities?** (Please tick)

    ☐ Trekking / Altitude ☐ Scuba Diving ☐ Cycling ☐ Rafting / Boating

    ☐ Other _____

15. **Date leaving New Zealand** _____

    Date returning to New Zealand _____

PRE-TRAVEL WORKSHEET
(to be completed by Medical Staff)

Vaccine	Number of Doses Required
☐ Hepatitis A	One injection, booster at 12 months will provide immunity up to 10 years
☐ Hepatitis A & B	Course of three injections. 0, 1 and 6 months.
☐ Hepatitis B	Course of three injections one month apart. Life long immunity.
☐ Japanese Encephalitis	Two injections. 1, 28 days after first injection
☐ Meningococcal ACYW	One injection. Booster at 2-3 years.
☐ Polio	One injection if had childhood immunisation. Booster every 10 years.
☐ Rabies	Three injections. 0, 7, 28 days. Booster at one year.
☐ Tetanus (ITETNS)	Give one injection if more than 10 years since previous booster dose.
☐ Typhoid	One injection. Three yearly booster.
☐ Hepatitis A / Typhoid	Booster six months. Revaccinate against Typhoid every three years.
☐ Cholera	Two injections. 1 and within 6 weeks.

Recommended Vaccinations [Please tick the vaccinations you wish to have and total the cost]

.....	$	.....	$.....
.....	$	.....	$.....
.....	$	.....	$.....
.....	$	.....	$.....

TOTAL COST OF TICK BOXES **$ _____**

RECOMMENDED MALARIA PROPHYLAXIS / ORAL MEDS

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I have been informed of the following:

- The vaccines being given today
- The care after vaccination
- The risks of vaccination
- The possible side effects
- The procedure to follow in the case of an adverse event

I am satisfied that I have received enough information today explaining both the benefits and risks of the vaccines to be administered. Any questions I had have been answered to my satisfaction. I have been informed as to the immunisation.

Sheet Prepared by ..... **Nurse**

Sheet Prepared by ..... **Doctor**

Date .....

I agree to pay the full cost of the vaccines before administration.

PATIENT'S AGREEMENT SIGNATURE _____

PRINT NAME _____

DATE _____